Department: Prior Authorization	**Policy Name: Outpatient Skilled Services, Home Health Services, Durable Medical Equipment, and Procedures Prior Authorization Process**
Policy Number: PA-001	**Page** 1 of 9
i) **Cross Reference: PA-104 IDP Urgent Prior Authorization Requests; PA-106 IDP Internal and External Reopen Requests, PA-115 Reasonable Outreach, PA-112 IDP Approval Letters, GA-048 Processing of Mail, PA-107 Management of Family Care Partnership Prior Authorization Requests.**	

Purpose:
Selected outpatient and in-home services require Prior Authorization (PA) for payment of claims. The PA process is in place in order to assure Independent Care Health Plan (*i*Care) members receive the appropriate level of care from providers and to mitigate potential Fraud, Waste, and Abuse (FWA).

Requests for PAs are completed by the ordering physician (PCP or Specialist), provider, or supplier and submitted to *i*Care for review of medical necessity and authorization of services/procedures that meet the medical needs of an *i*Care member. Upon receipt, urgent prior authorization requests are determined within 72 hours of receipt and fourteen (14) calendar days for all other non-urgent service and procedure authorizations.

Independent Care Health Plan does not impose additional requirements for telehealth services, and – where applicable – reviews requests for services at physical locations and telehealth services alike.

Process:

1) Medicare Part B Medication Requests
- a) Independent Care Health Plan follows CMS guidelines regarding timeliness of Part B Medication reviews. Urgent requests require determination within 24 hours of receipt, and non-urgent requests require determination within 72 hours of receipt.
- b) Prior Authorization staff will follow the guidelines for determining when a request meets CMS's definition of urgent as outlined in *PA-104 IDP, Urgent Prior Authorization Request Process*
- c) Prior Authorization Assistants
    - i) PA Assistants will split the authorization and enter one authorization for the drug and another authorization for all other service codes.
        - i. PA Assistants will enter an administrative approval for the drug authorization

ii. PA Assistants will follow notification timeliness requirements (including oral notification within 24 hours for Urgent requests).

ii) The PA Assistants will route the authorization for the procedure and other service codes to the PA Nurse to review, according to (2) Services and Procedures, below.

2) Services and Procedures:

a) Prior authorization (PA) is required for the procedures and services identified on the most current prior authorization listing on the Prior Authorization page of the *i*Care internet website: https:///www.icarehealthplan.org.

i) Independent Care Health Plan follows the Prior Authorization guidelines of the State of Wisconsin Department of Public Health as published on ForwardHealth, CMS Coverage Determinations, and Clinical Practice Guidelines as applicable to the specific PA request.

ii) Independent Care Health Plan reserves the privilege afforded to health insurance plans to include Prior Authorization requirements exceeding those determined mandatory by the State.

b) PA requests are received by fax (414- 231-1026).

c) A PA Assistant verifies member's eligibility including the presence of other insurance coverage.

i) Unique Family Care Partnership (FCP) PA request process: follow Management of Family Care Partnership Prior Authorization Requests (PA-107).

d) The PA Assistant and/or PA Nurse will verify the Provider's contract status by referencing the Provider Search Tool on the *i*Care intranet and/or communication by phone or email with Network Development staff.

i) The following services must be provided by a contracted provider: DME supplies (excluding oxygen, rental equipment during rental period, and large unique equipment), Home Health, O/P therapies and LTC Waiver providers.

ii) PA requests received from a non-contracted provider require the Chief Medical Officer (CMO)/Medical Director's review.

iii) Prior to denying a PA request as out of network, the PA Staff should verify that there

is an in-network provider available in the member's service area that can provide an equivalent service.

e) If a PA request is received with missing clerical information which prevents the authorization from being entered into TruCare the PA Assistant will contact the provider for the missing information.
   i) The PA Assistant will document the request for information on the PA request, or under Notes Summary in TruCare as needed.
   ii) Documentation should include who the PA Staff spoke with, what specific information was requested, who the information was requested by, as well as the date and time of the discussion/request. Once the requested information is received and an authorization is created, the PA Assistant will link his or her note to the corresponding authorization in TruCare.
   iii) If the missing information cannot be obtained by the PA Assistant within 24 hours, the authorization request is saved into Document Summary.
f) The PA request will be entered into TruCare by the PA Assistant and tasked to the Clinical Review Queue.
g) Missing information to support medical necessity.
   i) When *i*Care does not have all of the information needed to make a coverage decision, the PA Staff must make reasonable and diligent efforts to obtain all necessary information, including medical records and other pertinent documentation from the enrollee's provider(s). For the complete reasonable outreach process, see PA-115 Reasonable Outreach.
h) If the prior authorization request has been in a PEND status for 14 days then a 14-day extension will be requested for a determination will be made.
   i) Extensions to the applicable adjudication timeframe are permitted, as long as the extension meets the requirements at 42 CFR §§422.568(b)(1), 422.572(b)(1), and 422.590(e)(1), as appropriate.
   ii) Unless the extension has been requested by the enrollee, the extension must be in the enrollee's interest and either for purposes for requesting information from a non-contracted provider that is necessary to approve the request, or because of

extraordinary or exigent circumstances. An example of when a date extension could be warranted is when the member meets medical necessity criteria, but iCare is missing required documentation, such as a signed physician's order to complete the determination.

iii) To complete a 14-day extension, a letter will be written to both the member and the provider requesting extension and state why the extension is being requested as well as clinical documentation required for determination.

3) Approvals:

a) It is within the scope of practice of the PA Nurse or Behavioral Health staff to approve a PA that meets medical necessity and benefit coverage requirements according to Medicare/Medicaid criteria and guidelines.

b) The PA Nurse documents the approval of the PA under clinical review in TruCare, determines the authorization as approved, generates a Provider Notification form in TruCare and faxes to the provider.

c) When the PA Nurse approves the authorization, the PA Nurse also generates approval letters for the servicing and requesting providers, the member, and the PCP. These letters are sent to a bulk mailing vendor to distribute.

d) The PA Nurse must generate and mail the letter within the 14-day turnaround time required by the State of Wisconsin SSI and BC+ and the Centers for Medicare and Medicaid MCO contract requirements. See also PA-112 IDP Approval Letters.

4) Denials:

a) All denials are reviewed by the CMO/Medical Director.

b) Prior to making a final determination, the CMO/Medical Director will review the qualitative and quantitative outreach to providers that was requested. This documentation includes the number of outreach attempts as well as if they were appropriate to satisfy CMS guidance regarding reasonable outreach.

c) If the CMO/Medical Director concurs with the PA Nurse or Behavioral Health staff's recommendation to deny or reduce services in a PA request, the CMO/Medical Director

will document the denial/reduction in an Advisor Review note in TruCare and task the denial/reduction to the Evaluate Advisor Review Queue to generate a denial letter to the member, copied to the provider.

i) The denial letter includes the reason for the denial/reduction and states all applicable appeal rights as stipulated by contractual responsibilities within the appropriate line of business.
ii) The PA Nurse assigned to the review must generate and mail the letter within the 14-day turnaround time required by the State of Wisconsin SSI and BC+ and the Centers for Medicare and Medicaid MCO contract requirements and send the letter to the member through the bulk mail vendor and to the servicing and requesting Provider through fax directly from TruCare.

5) Urgent/Expedited Determinations (see also *PA-104 IDP Urgent Prior Authorization Requests*)

a) Urgent Determinations: All Urgent PA requests are reviewed by the CMO/Medical Director.
b) Independent Care Health Plan reserves the right to determine the medical necessity of any request for urgent determinations.
   i) Independent Care Health Plan will notify the provider and member that the urgent request has been denied and of the reasons used in this decision within 72 hours of the receipt of the urgent request.
   ii) All urgent requests "downgraded" to "routine" will follow *i*Care's PA policy for standard PA requests.
c) Urgent authorizations must be determined within 72 hours if the physician or *i*Care indicates or determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.
   i) It is required that the member and requesting provider are notified of the determination as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request.
   ii) Independent Care Health Plan will attempt to notify the member of the determination

both orally and in writing. The member must receive the determination within 72 hours. If the member is unable to be reached via phone, the approval must be sent out as priority mail.

iii) The requesting provider will be notified of the determination in writing via fax.

d) Independent Care Health Plan will extend the 72-hour time frame by up to 14 calendar days if the enrollee requests the extension or *i*Care justifies a need for additional information and documents how the delay is in the interest of the enrollee. The member must be notified in writing of the reasons for the delay and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.

6) Reopens (see also *PA-106 IDP Internal and External Reopen Requests*)

a) Definition: A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination/decision was correct based on the evidence of record.

i) Reopenings are distinct from the appeals process; they are not a "right"; a current appeal may not be in progress if a reopening is to be granted.

ii) Reopenings are granted at the discretion of *i*Care and may be requested by either a provider or *i*Care in order to revise an initial determination.

iii) Reopenings may be conducted at the request of a Qualified Independent Contractor (QIC), and Administrative Law Judge (ALJ) to revise a hearing decision, and the Appeals Council (AC) to revise an ALJ decision or their own review decision.

b) The decision to reopen or to not reopen is not appealable. If a reopen request is received and is found to be without merit, *i*Care will not process the reopen request.

c) Conditions under which *i*Care will consider a reopen request:

i) Reopenings based on clerical or minor error and omissions.

(1) If a mathematical or computational mistake is made, a transposed procedure or diagnostic code is provided in error, inaccurate data is mistakenly entered, or otherwise incorrect data is entered by mistake such as the provider number or date of service error is made, and these minor errors result in a decision that

is contrary to the decision that would have been made if the error(s) had not been present, a reopening request is appropriate.

(2) If there is new and material evidence that was not available or known at the time of determination and may result in a different conclusion.

(3) The evidence that was considered in making the determination clearly shows on its face that an obvious error was made at the time of the determination.

ii) Reopenings at the request of a QIC, ALJ and/or AC to revise previous judgments or decisions.

d) Reopenings may be requested by telephone or by submission in writing.

e) Timeframes to initiate reopenings:

i) Independent Care requested reopenings:

(1) Independent Care may reopen its own determinations within 1 year of the date of the initial determination or redetermination, or

(2) At any time if there exists reliable evidence that the initial determination was procured by fraud or similar fault, or

(3) If the initial determination is unfavorable to the member or provider, but only for correcting a clerical error on which the determination was based.

(4) Third party error does not constitute clerical error (§10.4, Medicare Manual, Ch. 34).

ii) Provider requested reopenings:

(1) Within 1 year from the date of the initial determination or redetermination for any reason, or

(2) Within 4 years from the date of the initial determination or redetermination for good cause, or

(3) At any time if the initial determination is unfavorable to the provider or member, but only for purposes of correcting a clerical error on which that determination was based.

(4) Third party error does not constitute clerical error (§10.4, Medicare Manual, Ch. 34).

f) There are no timeframes in which *i*Care is required to process reopenings; however, *i*Care

will process the reopenings no later than 30 days after *i*Care has approved the reopening request.

7) Tracking and Monitoring:

a) Prior Authorization requests that require review by *i*Care's CMO/Medical Director should be tasked for Advisor Review by day eleven (11) when possible for a standard authorization and by day 26 for a standard authorization that has a date extension in place.

b) The PA Nurse will utilize the "Open Authorizations by Service Type" report, located in *i*Care's Report Manager to ensure PA requests are reviewed timely and by order of receipt. The PA Manager is responsible for monitoring and reconciling this report on a regular basis.

8) PA Correspondence Policy

a) All mail correspondence that does not utilize the bulk mailing vendor and that is created prior to 2:30 p.m. will follow GA-048 Processing of Mail.

b) All mail correspondence that does not utilize the bulk mailing vendor and that is created after 2:30 p.m. will be processed same day via certified mail.

c) The Prior Authorization Department utilizes a bulk mailing vendor for the majority of correspondence. Files feed over from TruCare to the secured bulk mailing vendor nightly at 8:00 p.m. Correspondence is processed the following day at 8:00 a.m. The PA Manager enforces time frames to ensure that correspondence is timely.

d) All failed TruCare faxes will be sent to the "TruCare Fax Failures" fax mailbox queue for monitoring and follow up by the assigned staff.

Responsible Department: Prior Authorization
Responsible Party: CMO
Reviewing Department(s): Prior Authorization

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References: Medicare Managed Care Organization Manual (100-16), Ch. 13.
Recommended Distribution: All staff via Independent Care's SharePoint Site

Approvals:

Approved By: Mary Ellen Benzik	**Chief Medical Officer**	**Date: 10/27/2022 3:26 PM**
Comments:		
Approved By: Tony Mollica	**CEO/President**	**Date: 10/28/2022 12:01 PM**
Comments:		

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